RIVERSIDE UNIVERSITY HEALTH SYSTEM-BEHAVIORAL HEALTH
Mid-County Region Behavioral Health Advisory Board
Thursday, February 5, 2026

MEMBERS PRESENT	MEMBERS ABSENT	STAFF PRESENT		GUEST PRESENT
Walter T. Haessler, M.D Brenda Scott Dr. Vernita Black Don Kendrick Dolores DeMartino (via TEAMS)	Ramon Amado Martiza Camacho	Beverly McKeddie Sheree Glidden Hilda Gallegos Donna Sliva Tony Ortego (via TEAMS) Melissa Vasquez Steven Willis (via TEAMS) Sandy Idle	Maria Cruz (via TEAMS) Pauline Youlin-Bartlett Annette Arias Elizabeth Lagunas James Gayler Lauren Adamson (via TEAMS)	Amy K. (via TEAMS) Dr. Lena S.(via TEAMS) Honor M. (via TEAMS) Jenni J. Adrian C.

ITEM	DISCUSSION	ACTION/FOLLOW UP
Call To Order and Introductions	Brenda Scott called the meeting to order at 3:05 p.m. All in attendance introduced themselves.	
Minutes	The January 8th, 2026, meeting minutes were reviewed and accepted.	
Announcements	Melissa shared copies of the February 2026 Family Advocate Program Groups calendar (housed out of Rustin) to share which also provides a virtual option, both in English and in Spanish. Also, for the TAY Arena, the Family Advocates created a four-week session on Communicating with Love (in English) and this group (even though it is at the TAY Arena), it is open to community members as well as loved ones that are receiving services there,18 and over for the family members. They had their first group last night and unfortunately only one person showed up. The ladies did an amazing job regardless and next week (February 11th) they're going to be talking about written communication. They have a Spanish support group that's on Thursday nights. May is Mental Health Month (MiMHM) event is in the planning phase. There will only be one event this year, which will be held at Fairmount Park in Riverside on May 14th from 11:30 am to 3:30 pm.	
Correspondence	No correspondence received or reported.	
New Business- James Gayler – First Episode Psychosis	James Gayler, Behavioral Health Services Supervisor for the First Episode Psychosis program provided an overview for his program about what they do. Our program is located throughout Riverside County, and we have three different locations. Our first location is in Riverside, one in the desert, La Quinta and we applied for a grant about a year and a half ago and got approved for a third site to expand our services and that is our mid-county region located in Perris. This is our largest team that has expanded roles, including a substance abuse counselor and a parent partner. We are community based, therefore we'll go out to homes, schools, or wherever necessary. Even though we only have these three locations, we can serve the entire Riverside County area, except for Blythe at this time.	

New Business - First Episode Psychosis (Continued)	James went on to explain what psychosis is:
	• Psychosis is a symptom, not a disorder
	• Difficulty distinguishing what is real and what is not real
	• Positive Symptoms (something added to the human experience)
	  • Hallucinations (Auditory, Visual, Somatic, Gustatory, Olfactory)
	  • Delusions
	  • Thought Insertion/Deletion, Mind reading (self or others), Ideas of Reference
	  • Overvalued Beliefs/Unusual Thoughts: Special Powers, Supernatural Insight, Change to the body/function
	  • Persecutory Beliefs
	  • Grandiose/Erotomania
	• Negative Symptoms (something taken away from the human experience)
	  • Disorganized Communication (loose associations, circumstantial/tangential)
	  • Avolition, Anhedonia, Alogia, Asociality, and Affective Blunting (diagnostic)
	These are the main parts of what we look at with psychosis in those positive and negative symptoms. When a person is having an episode, we say that it's lasting at least seven days. It's not like someone had a really bad day or maybe somebody took a substance and they're having this experience. This is something that has been happening to them for seven days or more. So why call it the first episode psychosis? To be very brief on the research here, there's a study out if anybody wants to learn more about it called the RAISE Initiative in which the response after an initial schizophrenia episode and what they found is that the longer symptoms go untreated, the greater the risk of a person developing a substance use disorder, injuring themselves or becoming homeless or unemployed. People tend to do better when they receive effective treatment as early as possible. Some people who receive early treatment never have another psychotic episode. For other people, recovery means the ability to live a fulfilling and productive life, even if psychotic symptoms sometimes return. The overall research found someone who waited longer, like four or five years before seeking services, were more likely to be on disability more of their life, having a hard time getting back to work, back to school, or they may be more likely to stay at home with their parents longer term, or they probably had higher doses of medications and had more hospitalization history as well. The sooner we can get those services involved, especially reducing the stigma so that they're comfortable coming in, the better the overall outcomes are.
	Who do we serve? We're a specialty mental health program who focuses primarily on those who are having a recent onset of psychosis, between the ages of 12 up to 26 years old. There is definitely a need for those younger than 12, but we're just not quite set up for that at this time. There are other programs across the state that can go a bit higher in age range, and that's because sometimes the onset may occur a little later, especially in females, seeing that that they can have a later onset than males do.
	The diagnosis would involve looking at someone who preferably has affective or non-affective psychosis disorders, schizophrenia spectrum disorders or schizophreniform, or the affected ones such as major depression with psychotic features or Bipolar with psychotic features. We used to distinguish between those two, and now we see that the treatment model is very similar to where our teams work with them and the medication side being a little different. We can bring them in dependent on which one it is; we just want to make sure that we're looking at true psychosis diagnosis or psychosis-based diagnosis as opposed to a trauma response because sometimes they can very much look a lot alike, as well as any ongoing medical concerns.	

New Business - First Episode Psychosis (Continued)	The timeframes for the first episode psychosis that we're looking at is the onset first episode at some point in the last 18 months. This is the current criteria we have up until July 1st of this year, at which point we'll be looking to expand that out beyond the 18-month mark. I think we're looking at probably closer to three years based on the current research that's out in the field. We're waiting for our grant to fully expire before we're allowed to fully open all that up. The other significant point made here is that the services are voluntary, this cannot be someone who's being court ordered to come in or can't be on a conservatorship and the family saying you must do this because that can add to further trauma to the person. The only kind of exclusion criteria we have is anyone with an IQ below 70 or severe developmental delay. We do have a pretty good chunk of our current population that is on the autism spectrum, which does not rule them out necessarily. It's only if they're at a point where they are unable to benefit from therapy or if they struggle a lot with basic communication and insight, then they might be more appropriate for an IRC. We call the treatment model for what we do as the Coordinated Specialty Care, and we focus on shared decision making between the client, parents/caregivers, and the team. We put the members themselves in the driver's seat on identifying their own goals, as well as getting them to agree to what we're doing. A lot of the conversations are similar to the CFTM process, which are those child and family team meetings where we put the members at the center, and we see what their goals are and what we (the team) can do to help support them, delivered by a multidisciplinary team (psychiatry, therapy, case management, peer support, and vocational support). We focus a lot on functional recovery, so getting back to school, back to work, improving relationships with their family, friends, or getting them back to hobbies that they can feel they have some meaning in their lives. Using the coordination care model is shown to reduce symptoms, improve functioning and lowering hospitalization rates. This really helps out getting that service wrapped around so the whole team communicates rather than having one person wait to try and coordinate with somebody who's also off-site, or somebody else that slows things down. The entire team is usually in the same room most of the time so that they can coordinate care. So what this looks like is we have a psychiatrist who helps out with medication services, a clinical therapist who provides individual and family therapy, specifically focusing on cognitive behavioral therapy for psychosis, a BHS II (a case manager) who will provide real life solutions/linkage to services or resources in the community, and a TAY Peer who has that psychosis experience as part of their lived experience. All of them will provide those services and focus on getting them the support, education, employment, getting them an IEP if they don't have one, or a 504 plan, or getting them back to work or back to school. They will also provide a lot of psychoeducation for the parents, so they understand what's going on, as well as to the members. In addition to that, we also added a substance use counselor because we're noticing a lot of commonality between substance use either causing the onset of psychosis or the self-medication for the psychosis itself, and rather than trying to have them go out to see somebody else, having that person who's integrated into the team and has the knowledge of psychosis and coordinates within the team have been invaluable. They've been on our team for about the past six months now and at first, it was slow going, but once the members started meeting with her, they've all been improving. We went from one member willing to meet her to now we're up to seven or eight and they're loving it. She is a huge part of our program now. The parents are responding well to this because they are thirsty for this information of how do I help my loved one. The Coordinated Specialty Care model provides a 24/7/365 after-hours support line, where after clinic hours, on the weekends or holidays is staffed only by the clinicians and myself who are part of the program. So, if someone is calling in who's part of our FEP program and needs support, then they're guaranteed to talk to somebody who's at least familiar with psychosis itself, the model we're using and most likely is already aware of their case, their safety plan, and their needs. The overall services that we provide are individual/family/group therapy, supported education/employment, case management, peer support, psychoeducation, medication management and cognitive remediation.	

New Business - First Episode Psychosis (Continued)	What that means is when someone goes through psychosis, one of the other parts (their executive functioning) takes a bit of a hit the first time they go through the episode and causes a problem with attention and memory processing speeds. All that takes a big toll on their life because now it's harder for them to answer questions and takes some longer to get through a questionnaire. They may have a hard time sitting in class and paying attention. The family may think they're just being lazy, which is a pretty common thing we hear. But what it really is, is they're having a hard time processing information and just need more time. Cognitive remediation is kind of like playing games for them, but it's really like physical therapy for the mind and having them practice different skill sets, such as divided attention, focused attention, improving processing speed around auditory and visual information so that they can start building those skills back up. It may never get back to 100% where it was, but it helps to improve from where it would be without that. We also use that to help tie back into their real-life goals. James then provided a brief history of FEP in RUHS. Originally it started off at the TAY Center and there were select staff who were part of the drop-in centers, who got trained in what was called the origin model out of Australia. The staff there either promoted or moved on, so unfortunately a lot of that knowledge was lost. There were also slightly more narrow eligibility criteria, so people weren't always aware that it was a resource there. As time moved on, in 2022, the realization that there was a need for an independent standalone program, for staff who were trained as this was their only skill set or primary skill set. So now we have a dedicated staff. We had originally started with only eight staff. They had two sites and ongoing training and technical assistance from UC Davis, who are still with us to this day. We expanded services to include cognitive remediation, expanded eligibility criteria to meet the needs of the community, and expanded it to include multiple diagnosis as well as widening the age range as well. We were then able to get approval for a $1,000,000 grant through CYBHI Round-5 to expand and ultimately allowed the creation of the mid-county team. Our current total program staffing, we have 14 full-time staff as well as two part-time psychiatrists. The Riverside team has our main Office Assistant II, two clinical therapists, a case manager, a TAY Peer, and a Supervisor. La Quinta has a Behavioral Health Specialist (case manager), a clinician, and a TAY Peer. The Perris team has a BHS (case manager), a Substance Abuse Counselor, a clinical therapist, a TAY Peer and a parent partner. Total caseload for the whole county is 27. That's the current active families we have. That's 12 in Riverside, seven in La Quinta, and eight in Perris, and as of the time I made this presentation, we have two more who are currently on the onboarding process to increase those numbers as well. Since we've been online, we have received 139 total referrals. Of those, 135 were able to get assessed, four of them did not respond or did not want to come in. Of those 135 that were assessed, 50 of them ended up being enrolled. Of the 123 individual referrals, 72% came from within RUHS. We're getting some from schools, some from IEHP directly, and 5% came from self-referrals and in the last few months that's increased, we've been getting a few more self-referrals. We're working on getting an actual website constructed, and look forward to that soon. Of the overall 124 referrals that were assessed, 42 did not meet criteria as a lot of times they either were not having a true hallucination or delusion, or other times it was more substance induced and once they had sobriety, the symptoms had dissipated. Overall, 33%, or about 1/3 of the overall referrals were accurate and were good for eligibility, which is consistent with other counties (where they came in at around 20-25%), so we're slightly above that. Overall, 43 individuals have been enrolled and are in the program for about two years minimum and up to five years if they have an ongoing psychosis issue that's not resolving with medications. Overall, of those who were discharged, 10% completed 100 percent, 25% moved out of the area, and about 40% ended up withdrawing or refusing services. The overall demographics, which definitely speaks to the population throughout Riverside County, are 74% identifying as Hispanic, 5% as White, 2% Asian and 5% Black/African American and 14% as other or multiracial.	

New Business - First Episode Psychosis (Continued)	Statistically, our largest population is from 19 to 24 years of age. Gender statistics are equal with about 53% male and 47% female. Total services have calculated at over 7000, about 6600 hours of direct services to the members which includes assessments, medication, therapy, and crisis case management. In looking at whether the program is effective, we use a tool known as the Brief Psychiatric Rating Scale (BPRS) which is a clinician-rated scale measuring psychiatric symptom severity, anxiety, depression, hallucinations or unusual behavior. It also supports diagnosis, treatment planning and progress monitoring. This is something that's measured by the clinicians who are face to face with them and observe how often these behaviors occur. So over time, what we found was a clinically significant drop and meaningful improvement often defined as a 25-50% reduction from baseline where that reduction in the hallucinations themselves, reduction in the feeling of depression or anxiety that go with it. We also use a tool called the PWI called the Personal Wellness Index which is a measure of wellbeing based on their satisfaction across key life domains and is self-reported. Members report how satisfied they are with their life, their health, what they are achieving in their life and their personal relationships. Overall, we like to see a higher score here as a lower score means that the member is not very happy or in distress. A higher score means that the member is very happy or doing much better. So prescored overall, they did have a significant increase in their overall feelings of wellness from their own perspectives based on this tool. We also utilized a program satisfaction survey which included 19 families and 26 youth. A majority agreed or strongly agreed with the satisfaction survey statements that indicated that the program had increased hope and optimism about their (or their family member's) future, improved their understanding of mental illness and recovery, helped them feel welcomed and supported by staff, boosted their confidence in supporting their family member, strengthened their family relationships, reinforced the importance of family involvement in recovery, and provided needed help. Some of the common things that were said by the members in this survey were that they like the personal support; that everyone is nice, helpful and reliable; feel like they help me out with knowing about my symptoms; like working with the staff; happy that the program was able to work around their schedule; staff do a good job; love the support and resources this program has to offer; like how involved the staff are in their recovery and success; have great compassion for the staff; and like that they are accommodating to certain needs like transportation. In closing, James shared his contact information which is as follows: • Supervisor: James Gayler, LMFT, jgayler@ruhealth.org, 951-955-7157 • Referrals: FEPIntake@ruhealth.org • Main Office number: 951-358-6005 • Main Office Fax: 951-358-6622 A question was asked regarding whether the program accepts Kaiser Medi-Cal? James responded that as long as the member has straight Medi-Cal, IEHP or Kaiser Medi-Cal, they're able to be seen, but not if they have straight Kaiser.	

New Business – Lake Elsinore Children's Program – Pauline Youlin-Bartlett	Pauline Youlin-Bartlett, the Behavioral Health Services Supervisor for the Lake Elsinore Children's Outpatient clinic provided an overview of her program. We serve Medi-Cal eligible youth aged 0-21 experiencing behavioral health issues who reside in Lake Elsinore, Canyon Lake, Menifee, Wildomar, and Sun City. In some cases, we will refer 0-5 youth to the 0-5 program for Parent Child Interaction Therapy (PCIT) or 17-21 youth to Transitional Age Youth (TAY) to accommodate for developmental age-appropriate services. We are a public access program serving youth and families on an outpatient basis through a multi-disciplinary approach. Outpatient services are provided in the clinic, the community, in homes, in schools and any other natural support that the youth is engaged in. So sometimes we'll engage with members in their after-school program if that is warranted. We do a comprehensive assessment, considering a multi-faceted approach to tailor services based on youth's needs. Our clinical staff include Marriage & Family Therapists and Clinical Social Workers trained to develop care plans to accommodate the needs of youth and their families: biological, extended family, adoptive, or foster. We work as a multi-disciplinary team with a wraparound type of approach that includes therapists, psychiatrists, parent partners, behavioral health specialists and peer support partners. Our Marriage & Family Therapists & Clinical Social Workers are tasked with building rapport with our families to reduce stigmatization associated with behavioral health services & determine a youth's level of need. Our clinical therapists are the Intensive Care Coordinators who oversee all aspects of their members to include linkage to the designated team; recommendations for adjunctive support; weekly/daily oversight to assure continuity of care; and, collaboration across cross-agency disciplines to determine needs/services are being conducted to best suit the needs of the youth. We do participate in the child and family team meetings with DPSS to make sure that we are making good recommendations based on the clinical care of that member and sometimes through the schools or teachers to see how we can help in those aspects as well. We have two exceptional psychiatrists that specifically cater to the youth population with years of experience. While medication may be helpful, our psychiatrists consider a variety of factors and at times, even just monitor a child's behaviors before prescribing medication assistance. Our multi-disciplinary approach allows clinicians to regularly consult with our doctors to inform of new or changing behaviors, inform of concerns that may not be fully mitigated by therapy alone, or provide a bridge for members who are wary of utilizing medication as support. Our members always have voice & choice over all their therapeutic options. Misrepresentation of medication (and again it leads to the stigma) is that people think that medication can be addictive or once they start taking medication, I'm going to have to take it for the rest of my life, and parents voicing concerns such as "I don't want my child being on medication" and that's not necessarily the case. So again, a psychiatrist uses a multidisciplinary approach and works collectively with all the other team members to see if the benefits are being met and if we need to further assess for that. We have Behavioral Health Specialists (BHS). Our BHS's work with our teams to provide specified behavioral health services in any natural support: home, school, community, afterschool care, group homes. Intensive Home-Based Services (IHBS) are individualized, strength-based interventions designed to improve mental health conditions that interfere with a youth's functioning and are always looking for when a child is doing well and what we can work with to improve their mental health. Interventions are designed to ameliorate behavioral issues by building & supporting skills for the child and their identified support network. If even more intensive needs are identified, we can employ Therapeutic Behavioral Services (TBS), which have no time restraints (24/7 if clinically appropriate) and have more intensive in-service delivery. We can't go ahead and just do therapy for a child and send them back into an environment that doesn't sustain that behavioral change, we must also consider how parenting is affecting those behaviors. So, while we work Monday through Friday, 9:00 to 5:00, they can work evenings. They can work weekends, they can go to the child if they are having trouble waking up in the morning, they can go to the home	

New Business – Lake Elsinore Children's Program (Continued)	at 5:00 AM and get that kid into a routine. They'll start going to school and again, so that the caregivers understand what they need to do to model and continue that good behavior. Our Parent Partners are individuals with lived experience who provide mentorship and navigation through challenging circumstances; instill hope; promote self-advocacy; connect families to additional resources and services; cultural and community responsiveness to be respectful of all cultures and ensure services are delivered free of stigma. They'll assist families with how to engage the school to start a 504 or IEP process and they're always looking at the cultural and community response so that they can use that. And again, so that families don't become dependent on them, but they are independent in their natural state. They provide system navigation, assisting clients in navigating healthcare systems and services. Anyone that has tried to get medical services before knows how frustrating it can be sometimes to get through all the push this number, push that number, sorry, you got disconnected. It can be hard for our families to even ask for that initial hey, I need help. My child is struggling or I'm struggling and so for them to not be able to navigate that or to feel like they're being afforded, we always make sure that if we're not the appropriate service, that we're going to warm hand off them to the appropriate service, so they don't feel like they're getting pushed around. We're always working on skill building, teaching coping strategies and life skills so that the behavioral interventions can move forward and then we do some groups, support groups and workshops to foster a community and connection. One of our staff members has just started a caregiver group specifically for non-biological caregivers so that they can understand how different it is than being a biological parent and then just kind of bridge that gap to step parents, foster parents and adopted parents. We provide a higher level of care than a Managed Care Provider would. Our members are referred to us due to having a mental health disorder as defined by the DSM in which their behavioral issues cause severe distress or impairment of their mental, emotional or behavioral functioning. The members that come to our clinic are typically those that endure psychosis, suicidal ideation, trauma, exposure, running away, sexual exploitation, involved with CPS, gender identity, and then, of course, at risk of expulsion having frequent psychiatric hospitalizations or legal involvement due to the behavioral issues in connect with their mental health. We do intensive care coordination, which refers to the structured multidisciplinary approach designed to manage the health and social care of the individuals who require frequent, specialized interactions. The members that come to us are typically seen one to two times per week. We have broader engagement with our community partners, and tailored interventions that go beyond clinical treatment. We provide parenting classes; support groups; therapeutic play; art; individual, family and group therapy; psychiatric care; specialized psychological testing (if needed); and community outreach events. Each member has a designated Intensive Care Coordinator (therapist) who communicates & collaborates with all team members for successful outcomes. Our mission is to always foster healing and growth in the young people's lives and their families, through the collaborative partnerships that we have with families and the Community and strive to create a supportive and nurturing environment where every child and adolescent feels valued and empowered on their journey towards mental wellness. We know that mental wellness is not just about getting well when you come into the clinic, but you need to be able to sustain that when you're outside of the clinic. We're creating this independent coping skill pattern where life is going to be tough, probably for the rest of their life. But now they have some skills where if something else happens that's similar, they can go ahead and remember the things that they learned in treatment. We are committed to offering evidence-based interventions. We have a therapist who is trained in EMDR. Additionally, most of our staff have been trained in TFCBT, which is trauma focused cognitive behavioral therapy and about a 16-to-20-week intervention that specifically deals with trauma and helping children to restructure cognitive biases based on	

New Business – Lake Elsinore Children's Program (Continued)	that trauma. Currently, we have 227 members on the non-FSP track and 53 on the FSP track. When members are referred, we attempt to get them in for an assessment within 10 days of the referral. If an appointment is offered within 10 days and the family declines then obviously, we can go over the 10 days.	
Old Business	No old business items were discussed.	
Administrator/Managers Report	Beverly McKeddie provided an update for Children's Programs. For Children's Services, Kelly Grotsky who has been the Children's Desert Administrator, was promoted to the Adult Administrator for the county, so that is a huge change for us as an administration team. She was unable to join us today, but we anticipate that she'll be joining future meetings to get to know the mid-county folks. We have an MOU, a memorandum of understanding, routing right now with Riverside County, that will give us access to the 24 districts of the special education campuses. It won't guarantee us the ability to go on campuses and provide service, but for many districts, similar to San Jacinto, they do require an MOU in order to be able to access students on campus. This is going to open up a lot of services, particularly for our outlying areas such as the Palo Verde District, which is out by Blythe. It's going to allow more service providers to come on campus and serve kids there. BH Connect, the state mandated services that are to begin July 1st, we already provide PCIT as a department. We have contract vendors who are interested in doing those parent child interactive training therapies as well. There will be high fidelity wraparound, which will be our wrap team. We do more than what the state mandates, so we'll be providing the service of high-fidelity wraparound in the context of our program that has the transitional age youth peers and the behavioral health specialists. Those are not mandated services by the state. There are two other family therapy services which will be in place of MDFT, its functional family therapy (FFT) and multi systemic therapy (MST) and we already have two contract vendors who have applied to do the MST work and a couple others that are interested in FFT. So, for the next couple of months, we're going to be going through the application process and looking at awarding contracts for those services coming in July. In mid-county, we have our MOU with San Jacinto routing so that we can get our TOPS team back on campus and doing the work that they do well. They're finally closing out some of the Hemet families that they can see outside of school for that part of the grant. Beverly shared that, Alicia Arredondo, a longtime Senior Parent Partner, has been reassigned through Parent Support and Training due to some upcoming changes that are coming up there. But we lucked out, Cherylyn Klemens, who is our senior with the TOPS program, is taking on the role of our regional senior parent partner. We are very excited about that. Cherylyn has a dynamic personality and there are no limits to what she will do to ensure kids and families are served. We will be hosting The Hope Collaborative Spring into Hope event at the TAY Center (flyers to come). It's open to the community with lots of vendors; we sent people home last year with tons of food, clothing, and resources, April 9th from 4:00 PM to 7:00. Once the flyer is completed, it will be sent out.	

Administrator/Managers Report (Continued)	Beverly shared that for the entire region, they have two vacancies. May is Mental Health month event as mentioned previously, for the county is at Fairmount Park. However, we are planning and talking with our staff about how they'd like to celebrate with our members, something like the art show that Lake Elsinore Children's has pioneered, they also have done a Winter festival. We've done some events in Temecula previously with games and closing off the parking lot and inviting families in. So, we're looking at a smaller scale, but nonetheless celebrating with our community. Beverly also shared that they are redesigning some space at the TAY Center, putting in cubicles that will have more privacy and higher walls in that area, to provide better space for the psychiatric residents there, and additional space for staff. Lastly, she is hearing that they'll be in the Wellness Village, the Children's building, by December of this year. There is already signage up on the building, so it's coming along. Tony Ortego provided an update on the Mature Adult program. In mid county, we operate out of four clinics. We have our Wellness and Recovery clinics for mature adults in Lake Elsinore, Temecula, and in San Jacinto. We also operate out of the Perris location. We will be operating out of the new Wellness Center in Mead Valley, hopefully by the end of this year. Our mid-county four clinics are broken down into two different regions. We have the east mid-county region, which is the Perris and San Jacinto Wellness and Recovery for Mature Adults clinics. And then we have the southwest mid-county Wellness and Recovery for Mature Adults, which are in Temecula and Lake Elsinore. Beginning with the east mid-county region, services in San Jacinto and Perris, we have a total of 658 members. We have approximately 544 members that are in our Wellness and Recovery track and then we have another 114 plus members in our full-service partnership (FSP) track, with the full-service partnership track requiring the highest-level needs, and involves more intensive case management, etc. Amongst those two programs that total 658 plus, we have a lot of walk-ins between the two programs. We do a lot of field work, but we also have individuals coming into the clinic seeking therapy, individual therapy, and medication consultations with our doctors. All four sites provide psychiatric medication support, psychotherapeutic support such as individual therapy and group therapy, which are big. We do provide nursing support and wraparound case management. Some of the integrated group care initiatives we have would be linking consumers or members who have no primary care physicians to a primary care physician often through IEHP or the help of Molina and/or Kaiser depending on what managed care plan they may have. We are providing whole person health scores at the San Jacinto and Perris Clinics, and we'll be launching the whole person health score (WPHS) initiative in Lake Elsinore and Temecula later this year. We do receive quite a few referrals through partnering agencies, including our hospitals, both our psychiatric and our Moreno Valley Medical Center; also from Adult Protective Services, the Department of Social Services APS; in addition to that, other county clinics such as our adult behavioral health clinics in Perris, Hemet, Temecula, and Lake Elsinore. We partner very closely with Adult Protective Services, Department of Social Services, because we receive a lot of their high-level cases. HOPE housing is a great partner of ours, often helping us escalate emergency housing for seniors. So that way we can avoid having them be homeless or without shelter. We also work very, very closely with IEHP and their Enhanced Care Management program as well. Some of the key highlights of all the services that we provide amongst the four clinics would be the psychiatric services, where we provide psychiatric consultation and medication and nursing support, and a lot of the individual group therapies that are very active and case management, which probably accounts for about 50% or more of our services as well. Some of the group therapies that we offer at different locations is the cognitive behavioral therapy. We use it for anxiety and for other modalities that are aimed towards major depression or relieving depressive disorders. We do a lot of co-occurring groups. We have peer support and family advocates who work really well with our teams and our members to connect them to the vital resources that are necessary for them to remain stable and in housing.	

Administrator/Managers Report (Continued)	Amongst our active partnerships, we do have a lot of master's students for the 25/26 school year and we also entertain RUHS 2nd year medical residents currently from some of those clinics as well. Census for our Temecula and Lake Elsinore clinics as of last month was 629. Between the two, we have 506 Wellness members and 123 full-service partnership members. So, among all four clinics we serve over 1250 plus members, which is now one of our largest regions that we provide services to. In lieu of Lacey Fourong's absence today, Dr. Black was able to share with the group some of the statistics for the SAPT program, which Lacy submitted to Hilda in advance of today's meeting. The Lake Elsinore clinic has 212 members and is fully staffed, with no vacancies. The San Jacinto clinic has approximately 200 members and two vacancies, one Office Assistant and one Peer. The Perris clinic has approximately 209 members and two position vacancies, one Office Assistant and one Peer. The Temecula clinic has approximately 146 members and is fully staffed. In addition, she reported that The Lake Elsinore clinic will be participating in a community engagement on February 28, where they will have two prevention staff speak about substance use to educate the community/parents of students at the school district.	
Committee Reports	**Behavioral Health Commission (BHC) –** Brenda was unable to provide a report, due to her inability to speak/loss of voice. **Membership Committee** – Brenda was unable to provide a report, due to her inability to speak/loss of voice. **Children's Committee**- Don Kendrick attended The Children's Committee and shared several flyers with the group. He shared that the Children's committee had a presentation by an outreach coordinator from UPC, named Melissa. This is a nonprofit program, and when asked about insurance requirements, it was explained that they don't take any insurance and that everything is funded through their own internal fundraisers, but it's to help families and kids with special needs and/or with disabilities. A lot of their programs are focused in the desert but do have different programs throughout Riverside County. Don shared several flyers with the group to include a parent support group that focuses on parents embracing autism and a Survivors of Suicide Loss support group. Kelly Grotsky had shared that a youth EMC mid-county Intensive Case Management program (target date to open is February 18th) for the mid-county region. There should be teams in each region, but the first one will be here. Also, there was mentioned that the Mindful Body and Recovery program (eating disorder program) as of right now, does not serve the TAY population and were mentioning that there's a big miss in that population and they're trying to launch a program to serve that population in March of this year. Nhan Pham, supervisor for FNL (Friday Night Live program), did a blanket drive and they were able to get almost 1100 blankets donated to them. Mr. Pham said that he did have some blankets left over and to reach out to him if you need any blankets. **Criminal Justice Committee –** No new information here to report.	

Committee Reports	**Older Adults Committee** – Tony was pulled away from the meeting and therefore no new information was reported here. **Adult System of Care Committee –** Brenda was unable to provide a report, due to her inability to speak/loss of voice. **Housing Committee** – Brenda was unable to provide a report, due to her inability to speak/loss of voice. **Legislative Committee –** No information was shared at this time. **Veterans Committee –** Dr. Vernita Black reported that the Veterans Committee are really doing a lot of different things and are trying to work with the homeless, with fitness programs, and with disabled veterans.	
Next Meeting	The next scheduled Mid-County Regional Advisory Board meeting is set for Thursday, March 5th, 2026, at the Perris Adult BH Clinic, 450 E. San Jacinto Ave, Perris CA 92571.	Next meeting scheduled for March 5th, 2026.
Adjournment	The meeting adjourned at 4:30 pm.	

Mid-County Region Behavioral Health Advisory Meeting Attendance												
Calendar Year 2026												
Members	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
1. Walter Haessler, M.D.	X	X										
2 Brenda Scott	X	X										
3. Dr. Vernita Black	A	X										
4. Don Kendrick	A	X										
5. Dolores DeMartino	X	X										
6. Ramon Amado	A	A										
7. Maritza Camacho	A	A										